RESPONSE TO THE WIRELINE COMPETITION BUREAU'S REQUEST FOR COMMENT ON ISSUES IN THE RURAL HEALTH CARE REFORM PROCEEDING

DA 12-1166

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Submitted by the Indiana Telehealth Network

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The Indiana Telehealth Network (ITN) is one of the 50 remaining Rural Health Care Pilot Program (RHCPP) participants. We have conducted 3 separate RFPs with 115 HCPs. Of those, 74 (or 64%) have signed contracts for services under the ITN. Of the 74 participants, 24 are Critical Access Hospitals (CAHs), 31 are Community Mental Health Centers (CMHCs), 6 are Data Centers, 5 are Rural Health Clinics (RHCs), 4 are rural hospitals under 100 beds, and 4 are urban hospitals. Our urban hospitals make up 5.4% of our participants. However, they are an essential part of our network. Without our urban partner hospitals, our network would not have gotten off of the ground. Of our 24 CAHs, 37.5% of them are part of a larger urban healthcare consortium. As of June 30, 2012, the 466 packages we have submitted represent all but $215,523.41 of our original funding amount of $16,138,269.99. This represents 99.98% of our overall project funding commitment.

SECTION 1 - CONSORTIA

6a. Consortium application process

The ITN supports the use of consortium applications in the proposed Broadband Services Program. We also support the use of LOAs at the 465 request-for-services stage. When we first began signing contracts as part of our initial RFP, less than 20 hospitals (35%) initially signed contracts. Over the last three years, that number has risen to 32 (or 56%). Contrast that to our final RFP where 62% of the HCPs who participated signed contracts within 60 days of being presented with their best and final vendor offers. While the use of LOAs at the 465 stage does add administrative burden to the process, we believe the benefit of identifying and thoroughly vetting the eligibility of the interested HCPs from the outset far outweighs the additional administrative efforts. If we waited until the 466 stage to procure the LOAs, we might easily find that some of the sites weren't really eligible for discounts through the program.

6b. Post-award reporting requirements

The least burdensome way to collect information necessary to evaluate compliance with the statute and other relevant regulations would be to develop a streamlined online database with pre-populated drop-downs for reporting information at the consortium level. Also, consortium should have a way to indicate exemption from reporting requirements until they have received their first FCL.

6c. Site and service substitution

The availability for site and service substitutions in the Pilot Program has been extremely valuable, and should be carried forward to the Broadband Services Program.

SECTION II – INCLUSION OF URBAN SITES IN CONSORTIA

7a,b,c,d,e,f. Urban Site Issues

As noted above, only 4.5% of our sites are urban, however they are key to our continued success. However, all projects have unique needs. The ITN supports continuing the rule that originated in the RHCPP which required a non-de minimis number of rural participants. Of even greater importance would be a joint consensus between the FCC and CMS for the definition or urban and rural providers.

Flat percentages for all participants, regardless of their rural or urban status would reduce any risk of under-utilization of benefits for urban sites due to perceived barriers or slower adoption rates. Additionally, different benefit percentages would create additional administrative burdens on consortium.

The ITN cannot stress enough the importance of continuing to allow urban sites to participate in consortium. The future delivery mechanisms of healthcare through Telehealth and telemedicine will make the urban hubs increasingly more important to rural providers in delivering healthcare to the rural populations of America.

With the advent of Meaningful Use, HIE adoption, and Accountable Care Organizations, all providers, regardless of their location, will be working together to provide more seamless care to all Americans. ITN urges the FCC to not add any additional barriers to the future of healthcare delivery.

SECTION III – Eligible Services and Equipment

10a. Point-to-Point Connectivity

Just in the last several years since the original FCC Order was released creating the Pilot Program, telecommunications solutions have evolved and changed the way healthcare is being delivered. The

ITN encourages the FCC to be more general in defining the connectivity services and equipment that would be eligible under the new Broadband Services Program.

10b,c. Eligible Non-Recurring Costs (NRCs) and Limited Funding for Construction of Facilities

Many Pilot Program projects used funding under the RHCPP primarily for construction and NRCs. The ITN's initial budget did not contain any monthly recurring charges. However, under our original RFP, after the first batches of contracts for infrastructure and plant upgrades by the winning vendors were signed, we still had a large amount of funding remaining. At that time, we submitted a Change in Scope to USAC to include monthly recurring charges for our leased services. Several of our sites required construction builds of over 20 miles of fiber to reach the nearest fiber node. It is in these extreme cases that rural healthcare providers and their surrounding communities would continue to be without adequate broadband services if not for the assistance of the RHCPP. At a minimum, the ITN supports the inclusion of the initial costs for routers and bridges associated with the installation of broadband services to eligible HCPs.

10d. Ineligible sites and treatment of shared services/costs

At this time, the ITN only has eligible HCP participants. Without the 85% benefits of the RHCPP, none of the ineligible HCPs that we worked with wanted to participate in our network. Regardless, we believe that a "fair share" approach similar to what was used in the Pilot Program would be appropriate for the Broadband Services Program.

SECTION IV – COMPETITIVE BIDDING PROCESS AND RELATED MATTERS

11a. Competitive Bidding Process

For consortia with projects over $100,000 in support, RFPs are a very valuable tool. However, RFPs do add a considerable amount of administrative burden to a program. In the NPRM for the Infrastructure Program, there was discussion regarding the funding administrative costs. During the Pilot Program, administrative funding was one of the biggest barriers in getting projects off the ground. The FCC may also want to consider administrative funding under the Broadband Services Program.

For new or expanding consortium, the addition of a RFP template on the USAC website would be extremely helpful. For existing consortium, a streamlined bidding process to renew pricing on existing services would be more appropriate. In any case, a single HCP should not have to go through a detailed RFP process.

11b. Requirement to Obtain Competitive Bids

Becky Sanders, Director of the ITN, also works with several HCP in the USAC RHC Primary Program. In many of these cases, no vendors bid on the 465s under the Primary Program. In cases such as this, a streamlined service provider selection process would be more appropriate.

11c. Multi-Year Contracts

The inclusion of evergreen contracts under the Broadband Services program would indeed reduce the administrative burden of annual filings. In general 3-5 year contracts are the most common. However, some of the Pilot Programs entered into IRUs or dark fiber leases for as many as 20 years. In this type of scenario, there is usually a large up-front payment due to the telecommunications provider. If many consortiums took advantage of long-term contracts with large up-front payments, it could prove troublesome for the Broadband Service program.

11d. Existing Master Services Agreements (MSAs)

Yes, the Broadband Services program should permit applicants to take services from an MSA, as long as the Master Contract was awarded through a competitive bidding process.

11e. Eligible Service Providers

The term eligible service providers should be broadly defined under the Broadband Services program. Pilot Program participants may have contracted with service providers that are not normally eligible under the RHC Primary program. This issue should be considered carefully as Pilot Programs begin transitioning out of pilot and into the revised primary or Broadband Services program.

SECTION V – BROADBAND NEEDS OF RURAL HEALTH CARE PROVIDERS

12 a,b,c,d – Telemedicine, Electronic Health Records, Other Telehealth Applications, Service Quality Requirements

The next 3-5 years will bring many changes to the way healthcare is delivered in America. Already, the broadband needs of several of our HCP sites under the Pilot Program have outpaced their original bandwidth choices, and they have been able to upgrade their services through site and service substitutions. The only thing that is certain is that broadband needs will continue to grow as technology changes over time.

12e. Cost Savings from Broadband Connectivity

Several of our HCPs were able to double their initial bandwidth under the Pilot Program for very little change in their costs. Other cost saving in healthcare delivery that will become more apparent over time will include improved efficiencies through the use of videoconferencing and Lean Healthcare strategies. We have begun to collect detailed information on these cost savings, but do not have them in time to include them with our comment at this time.

We thank the Commission for the opportunity to provide feedback in this matter.

Respectfully submitted,

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